Development of Hermes, a new person-centered assessment tool in nursing rehabilitation, through action research

Kristjánsson, Kristján; Thorarinsdottir, Kristin

DOI:
10.1097/ANS.0000000000000132

Document Version
Peer reviewed version

Citation for published version (Harvard):
Kristjánsson, K & Thorarinsdottir, K 2017, 'Development of Hermes, a new person-centered assessment tool in nursing rehabilitation, through action research', *Advances in Nursing Science*, vol. 40, no. 2.
https://doi.org/10.1097/ANS.0000000000000132

Development of Hermes, a New Person-Centered Assessment Tool in Nursing Rehabilitation, Through Action Research

Kristin Thorarinsdottir, RN, BScN, MScN;

Kristin Bjornsdottir, PhD, RN;

Kristjan Kristjansson PhD

In this article, an action-research project has been outlined, aimed at exploring ways for developing an assessment tool, underpinned by phenomenology, which would enhance a person-centered approach to the participation of patients in nursing assessment and care planning in rehabilitation. Participants were nurses in physical rehabilitation and a consultant. Data were collected by interviews and observation of the documentation on the tool. The tool, Hermes, was adopted in practice. Through its use, important person-centered assessment practices were enhanced and several aspects of its phenomenological grounding were supported. Hermes has potential for facilitating the transfusion of phenomenology into nursing practice.

Key words: action research, nursing documentation, patient participation, person-centered assessment tool, phenomenology, rehabilitation

Introduction

Person-centered care, as well as patient participation, are central ideals in nursing[1] and rehabilitation practices.[2,3] These ideals involve listening to and acknowledging patients' experiences of illness, preferences and needs, as well as the sharing of power between patients and health-care professionals, with the explicit aim of involving patients in health-care decisions.[3,4] The moral values of respect and equality in communication appear to be central to person-centered participation from patients' perspectives, as well as the patients being viewed and understood as unique individuals, from a holistic perspective, by taking their life situations into full consideration. Moreover, patients emphasize the need for the development of a deep understanding of the illness situation and its possible remedies, enhanced through a dialogue with health-care professionals.[4]

In this paper, an action-research project will be outlined where an assessment tool, underpinned by existentialist phenomenology, was developed in order to enhance a person-centered approach to the participation of patients in nursing assessment and care planning in rehabilitation. The tool, which was named Hermes, was developed with the participation of nurses at two wards in physical rehabilitation. At those wards, the majority of the patients suffered from physical illnesses of neurological, musculoskeletal and cardiovascular origin. One of the wards was for adult patients and the other for patients 67 years or older.

Patients in physical rehabilitation typically experience major disturbances to their daily lives due to impaired physical abilities. More specifically, these disruptions of function or well-being become their primary existential focus, in contrast to their previously perceived state of health where they could fully attend to the world and their life projects according to their immediate desire.[5,6] Understanding the physical illness trajectory is an ongoing process of re-interpretation of experienced disturbances, [7,8] typically driven by the patient's quest for establishing a new meaningful order in living with the disabling disruptions.[9,10] In such contexts, the existential and hermeneutical assumptions of Heideggerian phenomenology, fundamental to nursing practice,[11-13] have been found to be of particular relevance for physical rehabilitation. These assumptions posit human agents as interpretative beings who strive to understand and make sense of their existence in the world,[14] with the anchor of this existence being their very bodies.[6,15]

The motivation for developing Hermes arose in response to a project aimed at implementing standardized documentation systems at the two respective rehabilitation wards. Thereby, the existing nursing assessment was structured according to the well-known matrix of the 11 Functional Health Patterns (hereafter: FHPs) which capture the

bio-psychosocial aspects of health for standard nursing assessments.[16] The assessment was performed and written by a nurse in the traditional way: namely, mostly from a third-person perspective rather than the first-person perspectives of the patients. The assessment was followed by a care plan consisting of NANDA nursing diagnoses,[17] goals and nursing interventions, stated according to NIC (Nursing Intervention Classification).[18]

As the project progressed, it became apparent that the perspective of the patients did not reveal itself satisfactorily in the existing nursing assessment at the wards. Neither were the stated nursing diagnoses and care plans discussed with patients. These observations concur with a critique of standardized documentation as being distorted, fragmented and failing to capture patients' experiences of illness.[19] The practices in question raised concerns among the nurses and were identified as needing improvement since a person-centered approach was independently emerging as a central aim at the wards. This recognition provided the platform for the action research through which Hermes was developed. Hermes, like the messenger God it was named after and to whom the discovery of language and writing has been credited,[20] was intended to serve as a mediator between patients and nurses. More specifically, it aimed at capturing and mediating patients' experiences and meanings of illness through writing and dialogue, as well as synchronizing with the existing nursing documentation systems.

In addition to drawing upon existentialist phenomenology, Hermes was informed by a review of earlier person-centered assessment tools. In line with action research, the development of Hermes involved integration of the theoretical background into practice, within which its usefulness was evaluated.[21]

The phenomenological background and aims of Hermes

Hermes was influenced by Heidegger's hermeneutical and existential phenomenology,[14,15] with considerable additional input from Merleau-Ponty[6] and Gadamer.[22,23] Since many theoretical assumptions of phenomenological philosophy were found crucial for the development of Hermes and its eventual evaluation, these assumptions are explicitly stated here in the form of general aims. A crucial question about the theoretical adequacy of Hermes will be to what extent it succeeded in heeding these general aims.

Heideggerian phenomenology centers around people's experiences of everyday life and the meaning of those experiences.[14,24] Within this phenomenology, 'meaning' is understood in two distinct but related senses. First, it is defined as the essence and the significance of the lived experience, or the totality of the main structures of that experience, grasped holistically.[25] Second, 'meaning' denotes the ways people make sense of their experiences: that is, how they render them meaningful in their contexts of relevance.[14,26] Both these denotations carry significance for Hermes and thus they were adhered to jointly.

In hermeneutical phenomenology, which incorporates existentialist assumptions,[17,27] people's lived experiences and meanings are explored from a first-person point of view through a reflective, narrative, interpretative dialogue with another.[25,28] Such dialogue will be referred to as a 'phenomenological dialogue'. Inherent in existential phenomenology is the core assumption that we *are* our bodies through which we experience the world.[6] In line with this assumption, the overarching aim of Hermes was to *explore patients' lived experience, as embodied beings, of their illness, revealing its central aspects, as well as exploring how people render those experiences meaningful in their contexts of relevance.* These were to be explored through a reflective, interpretive dialogue between the patients

and the nurses. The following section outlines how the specific aims that contributed to the overarching aim were developed through Heidegger's so-called 'existentials'.

Heidegger understood his phenomenology as constituting a 'fundamental ontology' as well as an epistemology of experience.[14] His starting point was what he calls *Dasein*, or the being-there of human existence. His phenomenology was concerned with investigating different modes of what it means *to be*, as well as how human beings are caught up in meaningful activities.[14] The 'existentials' or 'modes of being', through which Heidegger assumes we make sense of our being in the world, are: understanding; attunement; articulation by language and being with another;[14] and the body as lived.[15,24] These existentials, in which the one of understanding is overarching, are thought of as intertwined, as they always work together inseparably.[14,15,24] In this way, people strive to understand their existence through their bodies, attunement and articulation through language and dialogue with another.

Understanding

The mode of being that strives to understand its own manner of existence in the world is overarching in Heidegger's phenomenology.[14,26] Heidegger makes it clear that all our understandings of the everyday world are derived from our interpretations of it.[14] His view thereby tallies with the more general hermeneutical understanding that every person has a unique life world, or horizon of being, shaped by virtue of his/her history, culture, relationships and language. Thus, people come with a 'pre-understanding' to each situation, a foundational structure for understanding.[14] In this context, Gadamer[22] uses the concept of 'horizon' in order to describe each individual's understanding. He argues that a horizon is the range of vision encompassing everything that can be seen from a particular vantage point which, in turn, presents the meaning perspective of the individual. Patients

typically understand their illness in terms of the disruption it has on daily life, with their understandings being shaped by their biography and unique life situation, whereas health-care professionals tend to understand the illness from the horizon of their expert knowledge as well as from their own life situation.[29] Thus, in accordance with the overarching mode of understanding, Hermes aimed at *helping patients as interpretative beings to interpret, understand and make sense of their illness situations, as well as helping nurses understand those situations from the patients' perspectives.* Moreover, in accordance with phenomenological philosophy (see discussions of embodiment and attunement below), the focus in Hermes was on how the relevant health issues disturbed well-being and daily life.

Embodiment and attunement

Heidegger argued that everything we refer to as our lived body, such as our hormones or muscle fiber, belongs essentially to our mode of existence.[15,24] Complementing the insights from Heidegger about mind-body unity is Merleau-Ponty's insistence that we, as humans, are embodied beings, primarily experiencing our body as the subject that we are. In this way, our bodies are our vehicles of being-in-the-world through which we live, interact with, experience and understand that world.[6]

In emphasizing embodiment, Merleau-Ponty argued, by drawing on Gestalt psychology, that we develop stable patterns of experience that tell us how to move our bodies in order to respond satisfactorily to various psychological and social situations.[5,6] These patterns build up over time, becoming 'sedimented' and free from immediate attention. Normally, the healthy body is experienced as the subject and as, in a sense, transparent, namely taken for granted and free from conscious awareness. This ability to free our attentions from ourselves, that is from our lived body, has central importance for

human beings as it allows them to engage with full attention with the world according to their immediate wishes and desires.[5,6] In times of illness and other challenging situations in our lives, however, we become aware of those patterns as they are no longer absent from our awareness but stand out as disturbing and interfering with our plans and actions.[30] In this disruptive illness state, the body is no longer experienced primarily as the subject that we are but rather as an external, protruding object.[23,30] Consequently, the world of everyday life becomes disturbed, as movements and abilities that are taken for granted fail. In this way, our lived world 'shrinks', as we no longer have freedom to fully attend to it, with the attention focused on our disturbing bodies.[23]

Thus, patients' experiences of illness typically centre around the disturbances and impact the illness has upon everyday life.[29] This focus brings us to the Heideggerian existential or mode of attunement, signifying that patients are attuned to these obtrusive impacts of illness upon everyday life. In this mode, we attend to things as being significant: as mattering,[14,31] implying that things show up as mattering to us – as attractive or threatening, useful or stubborn, and so forth.[32] Thus, in accordance with the existentials of embodiment and attunement, the structure of Hermes aimed at *facilitating patients in describing their embodied being, helping them in framing these disturbances as an important aspect of their illness experiences and as being a major concern to them.* Asking patients to address the severity of these disturbances was intended to provide insight into how well the patients were attuned to the disturbances.

Drawing upon the insights of Merleau-Ponty, Heidegger and Gadamer, it was hypothesized that the disturbances of everyday life due to the physical illness are posing a threat to the meaningfulness of daily life, as they disrupt our freedom to engage fully with our world and life projects according to our desires. Thus, our life is made chaotic, out of

order and not fitting into our established context of life.[26] Accordingly, Hermes aimed at helping people in framing and re-framing those disruptions through rehabilitation as well as viewing them holistically and in context. By so doing, the aim was *eventually to help people make sense of (as distinct from merely accepting) the illness situation through therapeutic rehabilitation practices, by establishing a new order to their lives, involving the creation of more spaces for attending to the world and their life projects according to their desires.*

Language and dialogue with another

The existential of language[14] is of crucial relevance for Hermes as it is the medium by which self-understandings and communication with others is structured (that is, through text) and in fact through which the other modes of being are also structured and made visible. Moreover, language, in Gadamer's philosophy,[22] is a key manifestation of the mode of being with another, as the medium in which substantive understandings take place between people. In this respect, the phenomenological dialogue outlined earlier is central. Thus, Hermes aimed at *facilitating the exploration of patients' lived experiences of physical illness through language and reflective interpretative dialogue, as well as their significance (that is the severity of the disruption of the illness on daily life).*

Central to all phenomenological philosophy is the principle of openness, which essentially means attending to phenomena (in this instance, patients' lived experience of illness) as they present themselves to us.[25] Openness to the phenomena involves endorsing people's first person-voice by listening to and writing down their narrative descriptions of their experience. In this way, the phenomenon of interest can first begin to present itself, in its entirety.[25] By reflecting upon subjective experiences through such a co-operative process – namely by rigorously examining and elucidating the data of

experience – the gap between nurses and the patients can be narrowed and possibly overcome through 'phenomenological reverberation'.[28] Thus, it becomes possible for nurses, by using Hermes, to come to 'some understanding of the patient's experience of illness'[29] and subsequently craft assessments and interventions that take their cue from and reflect this understanding – a crucial starting point for genuine person-centered care, as distinct from 'mere participation'.[4]

Available assessment tools upon which Hermes drew

Many previous person-centered assessment tools aim to support communication of patients' perspectives of their illnesses, symptoms and needs, in order to integrate those into the making of appropriate health-care decisions.[33] Experimental studies have shown that in addition to highlighting health issues of concern to patients, addressing the importance of receiving help with health problems is valuable for improving the outcome of care.[34-36]

Three already existing person-centered assessment tools, foregrounding health issues of concern to patients and their preferences for receiving help, were instructive at various stages in the development of Hermes. Those were the electronic program Choice, applied by nurses and physicians for tailored assessment in cancer care,[34] COPM (Canadian Occupational Performance Measure), focusing on occupational challenges in rehabilitation,[37] and the Tidal Model, used in mental care.[19,38] In the two former tools, patients are asked to identify a health issue of concern to them and rate its severity on a Likert scale or a scale of 0-10. Subsequently, they are asked to rate the importance of receiving help, on such a structured scale.[34,37] The Tidal Model, however, distinguishes itself from the aforementioned approaches by its purported phenomenological underpinnings. The model assumes a narrative form of practice and aims to give 'the

voice of the patient' a hearing by understanding the patient through an exploration of the experiences and meanings of illness.[19] Through a review of patients' narratives, the importance of receiving help is explored, on the basis of which a person-centered care plan is constructed in lay language, co-created by the patient and the nurse.[19] Those three tools have been shown to contribute to consistency in care-planning priorities between health-care professionals and patients,[35] as well as improving communication between them;[39,40] contribute to patients' perceived actualization of preferred results;[35] reduce symptom distress and need of symptom management;[34] reduce critical incidences;[38] elicit more questions from patients as well as securing more provision of information;[41] and enable a thorough measuring of patients' progress.[37]

The relevance of the hermeneutical and existential currents of phenomenology in physical rehabilitation, which view the body as the anchor of existence, has already been argued for above. The very absence of these currents in the phenomenological philosophy of the Tidal Model was, however, the main reason for why we did not consider it suited for use in this setting. Moreover, the mental-health focus and the unstructured approach of the Tidal Model were seen as shortcomings for its possible use as a standard assessment tool in physical rehabilitation. Yet, in line with the Tidal Model's phenomenological underpinnings,[19] capturing patients' narrative experiences and meanings became a central issue in Hermes. On the other hand, other features in the structure of Hermes, where patients came to be asked to identify health issues of concern and their severity and importance, drew upon Choice and COPM.

Methods

The aim of the study was to develop and evaluate a person-centered assessment tool grounded in phenomenology for use in nursing in physical rehabilitation. The main

research question was: How can an assessment tool grounded in existential phenomenology be developed as a way for enhancing a person-centered approach to the participation of patients in nursing assessment and care planning in physical rehabilitation? The additional research question centered on how Hermes could be synchronized effectively with existing documentation systems.

Design

A participatory action-research (PAR) approach was employed, consisting of iterative cycles of *observing, reflecting, planning, implementing and evaluating*.[21,42] The active participation of practitioners in the development and transfusion of theoretical knowledge into practice by such repeated reflective cycles is central to this approach. Moreover, the realization that practitioners' direct participation in diagnosing the situation needs improvement is an essential platform for PAR. In this case, certain assessment practices needing improvements (outlined earlier) were initially identified at three exploratory meetings with five nurses and the researcher who also served a consultant (first author, KT). Those nurses were chosen to represent the views from all the nurses employed at the wards. In these meetings, the aims of the study were agreed upon, including the development of the phenomenological and theoretical background.

All of the 12 nurses employed at the two rehabilitation wards participated in a focus group (referred to as ward group) in the study. The five nurses who had participated in the exploratory meetings formed a smaller focus group (referred to as quality group). The consultant provided solutions in the form of the development of the background of Hermes, its use and structure. In line with empowering aspect of PAR,[21] her role was also to promote dialogic and productive relationships among the nurses as well as shared understandings and collaborative decision making. The role of the nurses in the quality

group was to work closely with the consultant through the study in developing the structure and use of Hermes, as well as supporting the other nurses in testing and evaluating its use in practice. The repeated iterative cycles of PAR were entered into as follows: The consultant's proposals for Hermes were reviewed by the focus groups (*observation*) and reflected upon (*reflection*); amendments to the structure and use of Hermes and its testing in practice were planned (*planning*). Hermes was then amended, tested out and evaluated in practice (*implementation and evaluation*). Included in the consultant's proposal for Hermes was educating the nurses about its phenomenological and theoretical background and its use. This education was continuous through the study, reinforced by explanation, discussion and reflection. During the study, seven versions of Hermes were tested out through seven action cycles.

Data collection

Data collection was carried out through focus group and individual interviews which lasted from 40-60 minutes each. Eight of the focus group interviews were conducted with the quality group and five with the ward group. All the five nurses in the quality group attended all meetings of that group. In three of the ward group meetings, nine of the 12 nurses at the ward participated but in two meetings, eight of them participated. Moreover, in-depth individual interviews were conducted with five of the nurses. Data from these interviews were recorded and written down verbatim, but data from the focus groups were recorded directly at the sessions. The interviews were guided by the semi-structured interview guide presented in Table I.

(*Insert Table I here*)

Furthermore, the consultant directly reviewed the documentation on Hermes, as well as recording observations of the same documentation from the other nurses. These data were recorded as minutes and logs, into which reflective notes were integrated. The data collection period lasted for 18 months. Permission for the study was obtained from the ethical committee of the hospital involved, number 10/2013. No demographic data were collected for the protection of the patients and nurses involved. Informed consent was obtained from the participating nurses.

Data analysis

A directed deductive content analysis was employed.[43,44] Such analysis is typically used to validate or extend existing theoretical background and is normally guided by fairly structured themes and questions.[44] This approach to analysis was appropriate for use in the study because the highlighted themes pertained to the realization of the phenomenological background of Hermes. In accordance with the method in question, familiarization with data was achieved by reading through all the data. Subsequently, the data were reviewed for content that corresponded to the themes. During this process, data pertaining to the themes were grouped into several categories. In line with PAR, the participating nurses contributed directly to the data analysis,[21] as well as all the authors of this paper. Four persons who were not directly involved in the study were consulted at the final stage of the data analysis for enhancing critical reflection of the study. Moreover, four of the participating nurses checked the final analysis.

Results and discussion

During the research period, Hermes was developed and became the standard of care for all patient groups in the two rehabilitation wards. The results of study are summarized in Table II.

(Insert Table II here)

Use of language and dialogue with another supported

The application of language and dialogue with another was supported via the adoption of Hermes as clarified in the following categories.

The structure of Hermes fine-tuned

Through its specific language use, the structure of Hermes focuses on helping patients communicate and interpret the disturbing impact of illness and its significance. This structure was fine-tuned during the study. The final tool consisted of 27 broad health-related issues in which the all the FHPs were covered. The interview through Hermes is initiated with the open question: 'Which health-related issues disturb your well-being or cause you the most inconvenience?' Then patients are asked if they feel or experience a certain broad health issue, categorized according to one of the 11 FHPs,[16] which is disturbing their lives or causing them inconvenience. A more specific clarification is provided for each broad health issue, for example a more precise definition of weight described as 'too heavy' or 'too thin'. If the patients consider the health issues disturbing and answer the question with a 'yes', they are asked to describe the disruption in more detail in the column, 'further comments'. In this way, patients' own narrative descriptions of health issues of concern to them are foregrounded in accordance with the phenomenological method.[25,28] Subsequently, the patients are asked to rate how disturbing the health issue is to their lives and how much inconvenience it is causing, using the words 'minimal', 'moderate', 'substantial', 'severe'. If the issue is considered to be a source of considerable disturbance, the importance of receiving help is to be discussed. The assessment structure of Hermes, which an example of with recorded assessment is depicted in Table III, was meant to guide the admission interview as well as being applied

for evaluation at discharge. In addition to 27 semi-structured questions, patients were now asked about their goals regarding the rehabilitation, their main strengths, how they had succeeded in managing their health problems, what had been helpful to them and what kind of further information and teaching they needed.

(Insert Table III here)

The first-person perspective made clear and patient participation enhanced

Observation of the documentation on Hermes revealed that the first-person perspectives of the patients regarding their descriptions of health issues appeared clearly on the tool and phrases in lay language were common (see example, Table III). This had not been the case prior to the use of Hermes. Furthermore, the assessment appeared, in general, to be detailed and thorough. The nurses emphasized that, through Hermes, patients *were assessing themselves*, in contrast to the traditional assessment where they as nurses were primarily assessing patients. In this way, the nurses observed, the new kind of assessment was more genuine and trustworthy, as it hailed from the patients themselves. More specifically, the nurses reported that, by assessing themselves, the patients participated in the assessment to a much greater extent than earlier. These reports, as well as the increased appearance of the patients' perspectives, support that patient participation was enhanced by Hermes, as had been aimed for. The enactment of a person-centered approach through Hermes is supported by the enhancement of the first-person perspectives which is central to that approach,[3,4] as well as to the phenomenological approach.[25,28] This area of impact is consistent with the quality of the previous person-centered tools upon which Hermes drew.[37,40,41] In this respect, the appearance of lay language in Hermes agrees in particular with the emphasis and impact of the Tidal Model.[19,40]

Structuring the assessment interview and enhancing dialogue

There was consensus among the nurses that Hermes was helpful in guiding the assessment interview and for discussing health issues of concern, as this excerpt highlights:

> The new assessment [Hermes] gets the interview going; it is possible to use certain starting points where you begin dealing with those aspects. Then you enlarge upon those a bit and receive information as a result.

It was emphasized, as an advantage of Hermes, that it opened up for discussion issues of importance for the patients that were not usually addressed, such as isolation and psychological distress. More generally speaking, nurses reported that the use of Hermes facilitated in-depth discussions of health issues.

These findings provide a positive indication that Hermes facilitated the exploration of patients' experiences through dialogue with the nurses, as had been the aim. Yet, the most challenging task was to develop an interview technique that would not obstruct the flow of the assessment interviews in spite of being semi-structured. It was reported that if too many health issues were addressed, the flow of the interview was obstructed. The first two versions of Hermes that were tested in practice were reported by the nurses to be too long, tiresome, tedious and distressful for the patients. This was in fact the most prominent hindering factor in the development of Hermes and caused initial distress and dissatisfaction with the tool. This negative evaluation was responded to by integrating a number of health issues in one broad issue. Subsequently, the nurses became more satisfied with the tool and began to mention its salient positive effects.

The development of interview techniques was extensively discussed in the meetings and centered on finding a balance between structuring the interview while sustaining an open approach. Here it was found more helpful to use open questions rather

than asking directly whether a health issue was disturbing. This applied to mental and social issues in particular.

Inherent in a true phenomenological dialogue is the core principle of openness, involving true willingness to listen to and understand personal descriptions and interpretation as they unfold, as well as being reflective vis-à-vis the phenomenon of interest.[25] As direct observation of the assessment interviews was not conducted during the process, it cannot be confirmed that they were open and reflective enough to actualize the full potential of the phenomenological method. Thus, further research such as ethnography is needed for exploring the actualization of a genuine phenomenological interview, upon which further development of Hermes can be based. Studies point to communicational training in the use of person-centered tools being important in fulfilling their potenial.[39,41] Hence, the practising of a phenomenological dialogue is recommended for the use of Hermes.

The final tuning of the assessment procedure

The use of Hermes became the standard of care for all patient groups in the two wards. The general procedure was established that on admission the nurses conducted the assessment interview, guided by the structure of Hermes, which they filled in simultaneously in cooperation with the patient through dialogue. Yet, in some cases patients wrote the assessment themselves before the assessment interview was conducted. In these cases, these assessments were then used as bases for the interview. The same methods were used to evaluate the progress at discharge. There were instances of patients who were not able to go through the self-assessment due to language difficulties or cognitive impairments. In those cases, the nurses assessed the patients themselves, as in the traditional assessment, but nonetheless used the structure of Hermes. During the study,

assessment time was reduced from approximately an hour to approximately 30–40 minutes. Hermes was sustained, as evidenced by its continued use one year after it became the standard of care. The use of Hermes for assessment and evaluation of all patient groups in rehabilitation is consistent with the evidenced use and general sustainability of COPM.[37]

Embodiment and attunement supported

The FHPs which were adopted into Hermes were regarded as presenting the bodily psycho-social patterns underpinning embodiment[6] and disruption of those in illness.[6,30] Observations of the documentation of Hermes showed that, in line with the existential phenomenology upon which the structure of Hermes was grounded, patients generally identified and communicated the disturbances that their illness had upon their lives from a bio-psychosocial perspective, guided by the FHPs, precisely as had been aimed for. We would argue that this impact is a strong indication of the penetration of the chosen phenomenology into practice. Moreover, this feature constitutes a clear enactment of a person-centered approach, within which eliciting patients' views of the impact of their illness from a holistic perspective becomes central.[4] These qualities of Hermes for enabling person-centered nursing practices, regarding the participation of patients in health assessment, is of central importance for practice, as this approach is fundamental to nursing[1] and rehabilitation practices[2] as well as being one of the main elicitors of quality in health care.[45]

Emergence of health issues of concern

Observation of the documentation and interviews with the nurses revealed that health issues disturbing the patients clearly emerged in Hermes (see example in Table III). Given that 'disturbances' are the most significant issues of the illness experience, signifying its

true meaning,[29] it can also be argued that by illuminating the disturbances, Hermes helps patients communicate their personal meaning of illness to the nurses. This finding speaks against a common misinterpretation of hermeneutical philosophy in general and phenomenological hermeneutics in particular, as claiming that each individual's horizon marks out some sort of a 'beetle in a box'[46] inside his or her mind that will remain completely opaque to others: in principle ineffable and incommunicable. In fact, nothing was further from the mind of phenomenologists such as Heidegger.[47] They saw meaning precisely as belonging to an inter-human world: in principle accessible to all human beings *qua* their perceptive or interpretative faculties (cf. [46] on the impossibility of a completely private language and private meanings). The problem is, however, that within this inter-human world, individual horizons rarely overlap completely. For example, it is important to be aware of the decisive gap that tends to exist between patients' experiences of illness and the way in which the illness is conceptualized and understood by health-care professionals.[29] It can be argued that by being able to identify and describe the relevant disturbances, the patients portrayed their perspectives and horizons of meaning to the nurses, thereby contributing to a fusion of horizons between them. The understanding of patient experiences and meanings has been regarded fundamental to nursing practice.[11,13,48] Thus, this potential quality of the tool of helping patients communicate their meaning to nurses must be considered of particular importance.

Helpful in identifying problems, but participation in care planning vague

The emergence of health issues of concern in Hermes was reported as a real advantage by the nurses, as it enabled them to identify the patients' real problems more promptly and rule out those that were less relevant. This flagging of issues of concern, on the patients'

terms, turned out to be useful when it came to the selection of the nursing diagnosis, as the following excerpt shows:

> The nursing diagnosis appears more or less in the patient's language on the format [Hermes]. So it is really very easy, as a next step, to write the nursing diagnosis.

Hermes was developed primarily in response to demands for person-centered care and secondarily to satisfy requirements for using standardized documentation systems. The adoption of the FHPs into Hermes, as well as the synchronization of issues of concern to patients with the selection of nursing diagnosis, suggest that the tool helps nurses in satisfying these demands.

A clear indication of a sustained discussion on the importance of receiving help with health problems (as had been aimed for) did not appear, however, neither in the observation of the documentation on Hermes nor the interviews with the nurses. Thus, in this respect Hermes unfortunately still lags behind the tools upon which it drew, in which the importance of receiving help to health problems is clearly addressed.[19,34,37] As this aspect

limits the potential of Hermes to enhance patient participation in care planning, it calls for further research and subsequent development of the tool.

Helpful for realizing severity of problems and in evaluating progress

Asking patients to address the severity of the disturbing impact of illness on a verbal scale was intended to provide insight into how well the patients were attuned to these disturbances.

In most cases, the severity of the disturbances was documented on four verbal scales in Hermes (see Table III) at least for half of the issues that were evaluated as

disturbing. This method was reported helpful by the nurses as it facilitated the realization of the severity of the problem, which was explained as follows:

> The patient might say 'I have difficulties with sleeping' in the traditional assessment. Yet, when the patient says it disturbs my day severely, you receive a clearer picture of the problem.

Assessing the severity of the problem at admission often turned out to be rewarding and was highlighted by the nurses as useful and meaningful, both for themselves and the patients, when the progress was evaluated at discharge. In fact, some of the nurses reported this as the most satisfying aspect of working with the tool, as the following excerpt shows:

> The most rewarding aspect is reviewing the sheet of paper with the client and ... sometimes there has not been much progress or change, but sometimes the changes are incredible, something that one would not become aware of without using this assessment [referring to the tool]. I find this extraordinary, and, indeed, the client often says, 'look, this is really so much different'...

This reflective sense of progress can be explained along phenomenological lines by how meaningful it was for patients to become aware of their increased freedom to engage with world.[23] Thus, it can be argued that the tool has demonstrated real potential, as aimed for, in helping people reframe their disruptions through rehabilitation practices in order to create the space which enables them to engage with their world anew in meaningful ways.

Understanding of the patient's situation enhanced

Dialogues with the nurses revealed that interviews conducted via Hermes, and/or the subsequent reading of them, substantially increased their insight and understanding of the patients' perceived situations, as aimed for. Indeed, this understanding was what the

nurses saw as the most enabling impact of Hermes. The increased insight contributed to their satisfaction with the tool, as reflected in comments such as: '*the assessment [Hermes] helps me really to see the holistic picture of the patient's situation' and the patients' perspectives of their illness situations appear more or less on the assessment'*, which were commonly used at meetings and in interviews. This understanding was also considered of substantial value when planning care in accordance with patients' perceived needs. This impact of Hermes has direct relevance for practice in line with what has already been said regarding the potential of contributing to a 'fusion of horizons' and thereby to mutual understandings between patients and nurses. With reference to Heidegger's assumption that people strive to understand their existence through the various existentials,[14] we submit that Hermes has indeed enhanced nurses' understanding of the patients' situations through the existentials upon which the tool was grounded. The fact that the patients communicated the disturbing impacts of illness in Hermes, as has been outlined above, indicates that the tool helped them, as intended, to conceptualize their illness situations as interpretative beings. Yet, as the patients were not direct participants in the study, it cannot be confirmed whether Hermes, as overall aimed for, enhanced patients' understanding of their situations through these existentials. Such understanding is central to the chosen phenomenological approach,[14] as well as being highly valued by patients.[4] Thus, lack of direct data about patients' experiences in the use of Hermes is a limitation of the current study. Consequently, further research is needed, in which patients' perspectives on the use of Hermes are explored.

Conclusion: Implications for phenomenologically driven nursing practice

Through the development of the theory-based, phenomenologically grounded assessment tool Hermes, for use in nursing, important aspects of a person-centered approach to the

participation of patients in health assessment were enhanced. This quality of Hermes must be considered of particular clinical relevance since this approach is central to nursing and rehabilitation practices as well as being a fundamental elicitor of the provision of quality in health care.

The clinical application of existentialist and hermeneutical phenomenology has been advocated by influential nursing scholars during the past decades.[11,12] Yet, as far as we know, Hermes is the first assessment tool in nursing that has been developed systematically on the basis of this philosophy. Moreover, given the constant threat of a theory–practice gap in nursing, we are pleased to be able to report that our study of the adoption of Hermes into practice shows that its phenomenological underpinnings were supported in several aspects. These findings augur well for the further transfusion of existentialist phenomenology into nursing practice. Thus Hermes must, according to our findings, be regarded to have considerable clinical relevance for nursing. Mindful of the contribution that phenomenology has made to the establishment of nursing as human science,[48] Hermes arguably has the potential to further strengthen the 'humanistic imperative' in the nursing discipline. That said, we acknowledge the limitation that an exploration of patients' own perspectives lay outside the purview of this study. Thus, there is need for further research and practical development, as has been acknowledged above. All in all, we conclude that the use of Hermes is meaningful for nurses in physical rehabilitation. Arguably, the same applies to patients in physical rehabilitation in their struggle for regaining health.

Existentialist phenomenological philosophy is particularly ill suited for gathering dust in academic ivory towers; it is meant to be a philosophy for real life. We are encouraged to see how the explicit application of this philosophy, through Hermes, seems

to be of clinical relevance for nurses, as they strive to help patients recreate existential spaces, enabling them to reengage fully with the world and their life projects according to their desires – disengaged from the disrupting impact of illness.

References

1. Manley K, Hills V, Marriot S. Person-centred care: Principle of nursing practice D. *Nursing Stand.* 2011;25(31):35-37

2. Negrini S, Ceravolo MG. The white book on physical and rehabilitation medicine in Europe: A contribution to the growth of our specialty with no boundaries. *Am J Phys Med Rehabil*. 2008;87(7):601-606.

3. Leplege A, Gzil F, Cammelli M, Lefeve C, Pachoud B, Ville I. Person-centredness: Conceptual and historical perspectives. *Disability & Rehabilitation*. 2007;29(20-21):1555-1565.

4. Thorarinsdottir K, Kristjansson K. Patients' perspectives on person-centred participation in healthcare: A framework analysis. *Nurs Ethics*. 2014;21(2):129-147.

5. Bullington J. Embodiment and chronic pain: Implications for rehabilitation practice. *Health Care Anal*. 2009;17(2):100-109.

6. Merleau-Ponty M. *Phenomenology of Perception.* Smith C, trans. London, New York, Routledge & Keagan Paul; 1962.

7. Salter K, Hellings C, Foley N, Teasell R. The experience of living with stroke: A qualitative meta-synthesis. *J Rehabil Med*. 2008;40(8):595-602.

8. Sharpe H, Alderson K, Collins S. An exploration of positive identity development in women living with chronic pain. *Qualitative Report*. 2013;18(29):1-22

9. Frank AW. *The Wounded Storyteller: Body, Illness, and Ethics.* Chicago and London: University of Chicago Press; 1995.

10. Kleinman A. *The Illness Narratives: Suffering, Healing and the Human Condition.* New York: Basic Books; 1988

11. Thomas SP, Pollio HR. *Listening to Patients: A Phenomenological Approach to Nursing Research and Practice.* New York: Springer Publishing Company; 2002.

12. Benner PE, Tanner CA, Chesla CA. *Expertise in Nursing Practice: Caring, Clinical Judgment, and Ethics.* New York: Springer Publishing Company; 1996.

13. Benner PE, Wrubel J. *The Primacy of Caring: Stress and Coping in Health and Illness.* Menlo Park: Addison-Wesley Publishing Company; 1989.

14. Heidegger M. *Being and Time.* Stambaugh C, trans. Rev ed. New York: State University of New York Press; 2010.

15. Heidegger M. *Zollikoner Seminare: Protokolle-Zwiegespräche-Briefe.* 3rd ed. Boss M, ed. Frankfurt am Main: Vittorio Klosterman; 2006.

16. Gordon M. *Nursing Diagnosis: Process and Application.* St. Louis: Mosby; 1994.

17. NANDA International (NANDA-I). *NANDA-I Nursing Diagnosis:Definitions and Classification 2009-2011.* Chichester: Whiley-Blackwell; 2009.

18. Bulecheck GM, Butcher HK, Dochterman JM, eds. 6th ed. *Nursing Intervention Classification (NIC).* St. Louis: Mosby; 2008.

19. Barker P. The tidal model: The lived-experience in person-centred mental health nursing care. *Nurs Philos*. 2001;2(3):213-223.

20. Palmer R. *Hermeneutics: Interpretation Theory in Schleiermacher, Dithley, Heidegger and Gadamer*. Evanston, Illinois: Northwestern University Press; 1969.

21. Stringer ET, Genat WJ. *Action Research in Health.* Upper Saddle River, NJ: Prentice Hall; 2004.

22. Gadamer H. *Truth and Method.* 1st paperback ed. Weinsheimer J, Marshall D, trans. London: Bloomsbury; 2013.

23. Gadamer H. *The Enigma of Health: The Art of Healing in a Scientific Age.* Graiger J, Walker N, trans. Cambridge: Polity Press; 1996.

24. Svenaeus F. *The Hermeneutics of Medicine and the Phenomenology of Health: Steps towards a Philosophy of Medical Practice.* Dordrecht: Kluver Academics Publishers; 2000.

25. Dahlberg K, Dahlberg H, Nyström M. *Reflective Lifeworld Research.* 2nd ed. Lund: Studentlitteratur; 2008.

26. Svenaeus F. Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. *Med Health Care Philos*. 2011;14(3):333-343.

27. Todres L, Wheeler S. The complementarity of phenomenology, hermeneutics and existentialism as a philosophical perspective for nursing research. *Int J Nurs Stud*. 2001;38(1):1-8.

28. Van Maanen M. *Researching Lived Experience.* 2nd ed. London, Ca: Althouse Press; 1997.

29. Toombs SK. *The Meaning of Illness: A Phenomenological Account of the Different Perspectives of Physician and Patient.* Dordrect: Kluwer Academic Publishers; 1993.

30. Leder D. *The Absent Body.* Chicago: University of Chicago Press; 1990.

31. Dreyfus HL. *Being-in-the-World: A Commentary on Heidegger's Being and Time, Division I.* Cambridge, Mass: MIT Press; 1991.

32. Dreyfus H. Husserl, Heidegger and modern existenialism. In: Magee B, ed. *The Great Philosophers: An Introduction to Western Philosophy.* London: BCC Books; 1987:254-277.

33. Haywood K, Marshall S, Fitzpatrick R. Patient participation in the consultation process: A structured review of intervention strategies. *Patient Educ Couns*. 2006;63 (1-2):12-23.

34. Ruland CM, Holte HH, Roislien J, et al. Effects of a computer-supported interactive tailored patient assessment tool on patient care, symptom distress, and patients' need for symptom management support: A randomized clinical trial. *J Am Med Inform Assoc*. 2010;17(4):403-410.

35. Ruland CM. Handheld technology to improve patient care: Evaluating a support system for preference-based care planning at the bedside. *J Am Med Inform Assoc*. 2002;9(2):192-201.

36. Wressle E, Eeg-Olofsson A, Marcusson J, Henriksson C. Improved client participation in the rehabilitation process using a client-centred goal formulation structure. *J Rehab Med*. 2002;34(1):5-11.

37. Law M, Baptiste S, Carswell A, McColl MA, Polatajko H, Pollock N. *Canadian Occupational Performance Measure.* Ottawa, ON: CAOT Publications ACE; 2005.

38. Barker P, Buchanan-Barker P. The tidal model of mental health recovery and reclamation: Application in acute care settings. *Issues Ment Health Nurs*. 2010;31(3):171-180.

39. Børøsund E, Ruland CM, Moore S, Ekstedt M. Nurses' experiences of using an interactive tailored patient assessment tool one year past implementation. *Int J Med Inf*. 2013. In press. http://dx.doi.org/10.1016/j.ijmedinf.2013.10.010. Accessed Nov 26, 2015.

40. Cook NR, Phillips BN, Sadler D. The tidal model as experienced by patients and nurses in a regional forensic unit. *J Psychiatr Mental Health Nurs*. 2005;12(5):536-540.

41. Heyn L, Finset A, Eide H, Ruland CM. Effects of an interactive tailored patient assessment on patient-clinician communication in cancer care. *Psychooncology*. 2013;22(1):89-96.

42. Koch T, Kralik D. *Participatory Action Research in Healthcare.* Oxford: Blackwell; 2006.

43. Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs*. 2008;62(1):107-115.

44. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. 2005;15(9):1277-1288.

45. Institute of Medicine (US). Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington (DC): National Academies Press (US); 2001.

46. Wittgenstein L. *Philosophical investigations.* Anscombe GEM, trans. Oxford: Blackwell; 1953.

47. Paley J. Misinterpretive phenomenology: Heidegger, ontology and nursing research. *J Adv Nurs*. 1998;27(4):817-824.

48. Meleis A. *Theoretical Nursing: Development and Progress.* 4th ed. Philadelphia: Lippincott Williams and Wilkins; 2007.